Commonwealth of Massachusetts
Health Care/Dependent Care
Participant Termination/Unpaid Leave of Absence Form

Date:

Total Pages:_____page, including this cover page

Attention of: **SHPS Spending Accounts**
Facsimile: **1.866.643.2219**
Telephone: **1.866.862.2422**

Name of Payroll Coordinator:
Telephone:
Facsimile:
E-Mail:

Agency Name:_____

Dept ID:_____

Name of Employee:_____

Check Appropriate Event: **Termination** **_____**

Unpaid Leave of Absence **_____**
(FMLA, Medical, NOP, etc.)

Date of Termination or Unpaid Leave of Absence:_____/_____/_____

Pay Check Date of Last HCSA and/or DCAP deduction:_____/_____/_____

Signature of Payroll Coordinator:_____

Additional Comments:

- **Keep the original in the employee's personnel file; fax a copy to the HCSA/DCAP administrator.**
- **The employee will be terminated from the HCSA/DCAP plan upon receipt of this form by the plan administrator.**
- **The Payroll Coordinator must inactivate the HCSA/DCAP deductions in the payroll system.**